TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Austin Pain Associates

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-16-3398-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance carrier has not correctly processed this bill to-date. On appeal, I addressed each denial reason with the carrier and received an almost duplicate upheld denial with no other response from the carrier. In addition, all coding on this bill is aligned with Medicare; however the carrier continues to deny inaccurately stating otherwise."

Amount in Dispute: $1,917.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Because the requestor's documentation does not support the billing of these codes consistent with the documented place of service, no payment is due."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2015	Urinary Drug Screens	$1,917.92	$94.54

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - A04 – Denied in accordance with 134.600(p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 181 – Procedure code was invalid on the date of service
   - 197 – Precertification/authorization/notification absent
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 217 – The value of this procedure is included in the value of another procedure performed on this date
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
   - 612 – No payment is made as Medicare uses another code for reporting and/or payment of this service. Submit corrections W/I 95 days from DOS
   - 758 – ODG documentation requirements for urine drug testing have not been met
   - 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT Code descriptions/instructions.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Was the respondent's position statement supported?
2. Were the services in dispute recommended under the division's treatment guidelines?
3. Did the requestor meet division documentation requirements?
4. Did the carrier appropriately request additional documentation?
5. Did the carrier appropriately raise reasonableness and medical necessity?
6. Were Medicare policies met?
7. Is the requestor entitled to additional reimbursement?

Findings

1. The Respondent's states, "Procedure codes are not billable from the doctor's office per Medicare Fee Guidelines." Per the Medicare Claims Processing Manual, Chapter 16 – 10, which states in pertinent part,

> *"Diagnostic X-ray, laboratory, and other diagnostic tests, including materials and the services of technicians, are covered under the Medicare program. Some clinical laboratory procedures or tests require Food and Drug Administration (FDA) approval before coverage is provided.*
>
> *A diagnostic laboratory test is considered a laboratory service for billing purposes, regardless of whether it is performed in:*
>
> - *A physician's office, by an independent laboratory;*
> - *By a hospital laboratory for its outpatients or nonpatients;*
> - *In a rural health clinic; or*
> - *In an HMO or Health Care Prepayment Plan (HCPP) for a patient who is not a member.*

The respondent's position statement is not supported and was not considered in the review of this dispute.

2. Per 28 Texas Administrative Code (TAC) §137.100 (a) states, in pertinent part, that "Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp..."* Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a). Review of the July, 2015 ODG pain chapter under the "Drug testing" finds that drug testing is recommended. Furthermore, ODG refers to procedure

description “Urine Drug Testing (UDT)” where UDTs are also described as “recommended.” The division concludes that the services were provided in accordance with the division’s treatment guidelines; that the services are presumed reasonable pursuant to 28 TAC §137.100(c), and Labor Code §413.017; and are also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

3. The respondent’s claim adjustment code 758 states that “ODG documentation requirements for urine drug testing have not been met.” Documentation requirements for the services provided are not established by ODG, rather, documentation requirements are established by 28 TAC §133.210 which describes the documentation required to be submitted with a medical bill. 28 TAC §133.210 does not require documentation to be submitted with the medical bill for the services in dispute. The carrier’s denial reason is not supported.

4. The carrier denied payment, in part, with claim adjustment code 225 citing that the documentation does not support the service billed, and that the carrier would “…re-evaluate this upon receipt of clarifying information.” Similarly, in its response to this medical fee dispute, the carrier cites the lack of clarifying information and/or documentation as a reason for denial of payment. The process for a carrier’s request of documentation not otherwise required by 28 TAC 133.210 is detailed in section (d) of that section as follows:

   Any request by the insurance carrier for additional documentation to process a medical bill shall:
   (1) be in writing;
   (2) be specific to the bill or the bill's related episode of care;
   (3) describe with specificity the clinical and other information to be included in the response;
   (4) be relevant and necessary for the resolution of the bill;
   (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   (6) indicate the specific reason for which the insurance carrier is requesting the information; and
   (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

   No documentation was found to support that the carrier made an appropriate request for additional documentation during the billing process with the specificity required by rule. The division concludes that carrier failed to meet the requirements of 28 TAC 133.210(d).

5. Health care provided in accordance with the ODG is presumed reasonable as specified in (c) of Rule §137.100. Section (e) of that same rule allows for the insurance carrier to retrospectively review reasonableness and medical necessity:

   > An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

   28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers’ compensation insurance coverage. Applicable 28 TAC §19.2003 (b)(31) defines retrospective review as “A form of utilization review for health care services that have been provided to an injured employee.” No documentation was found to support that the insurance carrier retrospectively reviewed the reasonableness and medical necessity of the service in dispute pursuant to the minimal requirements of Chapter 19, subchapter U. The insurance carrier failed to follow the appropriate administrative process and remedy in order to address its assertions regarding appropriateness of care and medical necessity.

6. 28 TAC §134.203(b) states that “For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiative (CCI) edits; modifiers; bonus payments for

health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

28 TAC §134.203(a)(5) states that "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, values and weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare." The services in dispute are clinical laboratory services; therefore, Medicare policies for the clinical laboratory services must be met. The services in dispute are addressed in the CMS Clinical Laboratory Fee Schedule. The requestor billed the following AMA CPT codes/descriptions as follows:

- CPT Code - G0431 Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
- CPT Code – G6052 Assay of meprobamate
- CPT Code – G6045 Assay of dihydrocodeinone
- CPT Code – G6046 Assay of dihydromorphinone
- CPT Code – G6056 Opiate(s), drug and metabolites, each procedure
- CPT Code – G6041 Alkaloids, urine, quantitative
- CPT Code – 82542 Column chromatography, includes mass spectrometry, if performed (eg, HPLC, LC, LC/MS, LC/MS-MS, GC, GC/MS-MS, GC/MS, HPLC/MS), non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen
- CPT Code – 82570 Creatinine; other source

Review of the National Correct Coding Initiative Manual found at,

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html, Chapter 12, Section 12, which states in pertinent part,

> *HCPCS code G0431 (drug screen... by high complexity test method..., **per patient encounter**) is utilized to report drug urine screening performed by a CLIA high complexity test method. This code is also reported with only one (1) unit of service **regardless of the number of drugs screened**.*

Chapter X, Pathology / Laboratory Services, CPT Codes 80000 – 89999, E. Drug Testing

> *Providers performing validity testing on urine specimens utilized for drug testing should not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed. The Internet-Only Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 16 (Laboratory Services), Section 10 (Background) indicates that a laboratory test is a covered benefit only if the test result is utilized for management of the beneficiary's specific medical problem. Testing to confirm that a urine specimen is unadulterated is an internal control process that is not separately reportable.*

Regarding the services in dispute, (G6052, G6045, G6046, G6056 (7 units) G6041, 82542 and 82570, pursuant to the above, the insurance carrier's denial reason 217 – "The value of this procedure is included in the value of another procedure performed on this date" is supported. The payable service in dispute will be reviewed per applicable rules and fee guidelines.

7. The services in dispute are eligible for payment. 28 TAC §134.203(e) states:

> "The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:
>
> (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and
>
> (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service."

CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a

possible professional component, for that reason, the MAR is determined solely pursuant to 28 TAC §134.203(e)(1). The maximum allowable reimbursement(MAR) for the services in dispute is 125% of the fee listed for the codes in the 2015 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov. The total MAR is calculated as follows:

Date of Service	Submitted Code	Submitted Charge	Units	MAR
July 15, 2015	G0431	$369.00	1	$75.63 x 125% = $94.54
			Total	$94.54

The total maximum allowable reimbursement for the services in dispute is $94.54. The amount previously paid by the Carrier is $0.00. The amount due to the requestor is $94.54.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $94.54.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $94.54 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.